

STATUS UPDATE/ANNUAL ASSESSMENT

PROJECT NAME											
CLIENT NAME											
PROJECT STATUS DATE	<table border="1"> <tr> <td></td><td></td><td>—</td><td></td><td></td><td>—</td><td></td><td></td><td></td><td></td> </tr> </table>			—			—				
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DISABLING CONDITIONS AND BARRIERS

Are you a survivor of domestic or intimate partner violence?

<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If Yes for survivor of domestic or intimate partner violence</i>		
<b>When did this experience occur?</b>	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Are you currently fleeing?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

MONTHLY INCOME AND SOURCES

<b>Income from Any Source</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY</b>		
<b>Income Source (Check all that apply)</b>	<b>Monthly Amount</b>	
<input type="checkbox"/> Earned Income		
<input type="checkbox"/> Unemployment Insurance		
<input type="checkbox"/> Worker's Compensation		
<input type="checkbox"/> Private Disability Insurance		
<input type="checkbox"/> VA Service-Connected Disability Compensation		
<input type="checkbox"/> Social Security Disability Income (SSDI)		
<input type="checkbox"/> Supplemental Security Income (SSI)		
<input type="checkbox"/> Retirement Income from Social Security		
<input type="checkbox"/> VA Non-Service-Connected Disability Pension		
<input type="checkbox"/> Pension or retirement income from a former job		
<input type="checkbox"/> Temporary Assistance for Needy Families		
<input type="checkbox"/> General Assistance (GA)		
<input type="checkbox"/> Alimony or other spousal support		
<input type="checkbox"/> Child Support		
<input type="checkbox"/> Other Cash Income (Specify: _____)		

# FY 2022 OC HMIS: STATUS UPDATE/ANNUAL ASSESSMENT FORM — SSVF

## NON-CASH BENEFITS

<b>Receiving Non-Cash Benefits?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>IF "YES" TO RECEIVING NON-CASH BENEFITS—INDICATE ALL SOURCES THAT APPLY</b>		
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> TANF Transportation Services	
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/> Other TANF-Funded Services	
<input type="checkbox"/> TANF Childcare Services	<input type="checkbox"/> Other Non-Cash Benefits (Specify Source): _____	

## HEALTH INSURANCE

<b>Covered by Health Insurance?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>IF "YES" TO COVERED BY HEALTH INSURANCE— INDICATE ALL SOURCES THAT APPLY</b>		
<input type="checkbox"/> MEDICAID	<input type="checkbox"/> Insurance Obtained through COBRA	
<input type="checkbox"/> MEDICARE	<input type="checkbox"/> Private Pay Health Insurance	
<input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> State Health Insurance for Adults	
<input type="checkbox"/> Veteran's Administration (VA) Medical Services	<input type="checkbox"/> Indian Health Services Program	
<input type="checkbox"/> Employer-provided Health Insurance	<input type="checkbox"/> Other Health Insurance (Specify Source): _____	

## ADDITIONAL INFORMATION

<b>Connection with SOAR?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
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I certify that the information above is correct to the best of my knowledge.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Staff Signature

\_\_\_\_\_  
Date

**DO NOT WRITE IN BOX BELOW – DATA ENTRY PERSONNEL ONLY (Optional):**

Date entered into HMIS: \_\_\_\_/\_\_\_\_/\_\_\_\_

Question	Answer	Comments
Was the hard copy of the Status Update/Annual Assessment form completely filled out correctly?	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Staff Name (verifying completion of Data Entry): \_\_\_\_\_